fourths of the difference for rates at January 1, 1988 and July 1, 1988; and four-fourths of the difference for rates at January 1, 1989 and thereafter. Similarly, a facility with an 8-year phase-in shall receive payments based on one-eighth of the difference for rates at October 1, 1985, January, 1, 1986 and July 1, 1986; two-eighths of the difference at January 1, 1987 and July 1, 1987; and so on, until attaining eight-eighths of the difference for rates at January 1, 1993 and after.

j. Subsequent to October 1, 1985, no adjustments to asset valuation shall be made for replacements of existing equipment for those facilities fully phased to FRVS payments. Adjustments at cost shall be allowed for capital improvements and additions. Capital additions of beds shall be subject to the per bed standard as computed in g. above that is in effect 6 months prior to the date the facility addition was first put in service as a nursing home. An adjustment to the FRVS rate may be requested if expenditures for capital additions and improvements totaling $0.40 per available bed day accrue in the cost reporting period utilized in establishing the per diem rate for the upcoming rate semester. Costs incurred during a cost reporting period that do not total $0.40 per available bed day shall not be included in the next cost reporting total. Thus, a 120-bed facility purchasing new equipment which does not replace any old equipment, and making capital improvements at a total unamortized purchase cost less than $17,520 during a twelve month cost reporting period shall not receive an adjustment to the FRVS rate in the coming rate semester or in any rate semester for those improvements or equipment. The cost of capital additions or improvements shall be

established on the date new beds are put into service, the date of completion for capital improvements, and date of acquisition for equipment or other purchased assets and recognized for FRVS purposes so long as the total indexed asset valuation does not exceed the current per bed standard except as provided below:

(1)(a) Effective July 1, 1996, providers whose indexed asset valuation exceeded the per bed standard at June 30, 1996, shall be limited to their June 30, 1996, indexed value until the rate period in which their total asset value is less than the current per bed standard.

(1)(b) Providers that entered into a legally enforceable arms length agreement prior to July 1, 1996 for the construction or purchase loans of additions (excluding bed additions) or improvements which were not previously reported in a cost report shall have those additions or improvements included in their indexed asset value when the cost report that includes those additions or improvements is used to establish the reimbursement rate. When the above above mentioned additions or improvements cause the providers indexed asset value to exceed the current per bed standard, the provider shall be limited to that indexed asset value until the rate period in which that indexed asset value is less than the current per bed standard. Documentation of the legally enforceable, arms length agreement must be submitted with the cost report in which the additions or improvements are reported.

(2) In no other circumstances other than in (1)(a) and (1)(b) above shall a provider's total asset value under FRVS exceed their current per bed standard.

(3) Any cost associated with capital additions or improvements which are not recognized in the FRVS rate due to the per bed standard limitation, shall not be allowed in any future FRVS rate.

Adjustments made to FRVS rates due to capital additions or improvements shall be subject to retroactive adjustment based on audit findings made by AHCA. For facilities with 5 to 10 years remaining to full FRVS phase-in, 50 percent of replacement cost shall be reimbursed as a pass-through cost as depreciation and interest expense; if 4 years are remaining in the phase-in, 40 percent; if 3 years remaining, 30 percent; 2 years remaining, 20 percent; and 1 year remaining, 10 percent. This pass-through reimbursement shall be recaptured by AHCA in entirety if the facility undergoes a change of ownership.

2. FRVS for facilities entering the Medicaid program subsequent to October 1, 1985.

a. The FRVS rate for facilities constructed subsequent to October 1, 1985 or existing facilities which enter the Medicaid program subsequent to October 1, 1985 shall be calculated as in 1.a.-h. and j. above. These facilities shall not be subject to any phase-in to the FRVS rate, and shall not have the option to elect reimbursement under Section III. G. 2. - 5.

b. The ceiling that shall apply to facilities entering the program subsequent to October 1, 1985 shall be the ceiling in effect 6 months prior to the date the

facility was first put into service as a nursing home. For facilities built prior to October 1, 1985 which enter the program subsequent to October 1, 1985, the ceiling at October 1, 1985 shall be deflated, using the FCCI Index, back to 6 months prior to the date the facility was first put into service as a nursing home.

3. Facilities that are currently participating in the Medicaid program but subsequently withdraw.

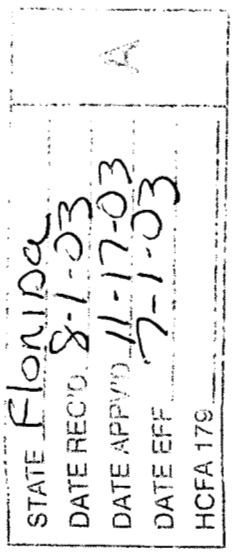
   a. Facilities that participate in the Medicaid program on or after October 1, 1985 but subsequently withdraw shall be subject to the same cost per bed ceiling that they were previously subject to should they decide to re-enter the program.

   b. At re-entry into the program, the indexing of asset valuation shall resume at the point where the facility was in the 40-year indexing curve per E.1.c. above when it withdrew from the program.

4. Property reimbursement for facilities upon change of ownership.

   a. Facilities that undergo a change of ownership on or after October 1, 1985 shall be reimbursed for property based upon the provisions contained in this section. It is the Agency's intent that, to the extent possible, the new provider shall receive essentially the same reimbursement for property costs as the previous provider. Therefore, unless stated otherwise in b. through f. below, the new provider's reimbursement shall be based on 1.-3. above.

   b. If the previous owner of a facility was being paid depreciation plus interest under the hold harmless provision of 1.h. above, the new owner shall also receive depreciation plus interest per Section III.G. unless he requests the Agency, in writing, to begin FRVS payments instead. The FRVS depreciable basis shall remain the same as that of the previous owner; interest expense allowed, subject to the limitations in 1.f. above.



c. If the previous owner was being reimbursed under FRVS, the new owner shall also receive FRVS payment, entering at the point of phase-in and asset value indexing that the previous owner had reached. If the new owner's principal balance of all current mortgages is less that 60 percent of the indexed asset value, only the interest portion, at a rate determined in 1.f.(4), will be used in calculating the new owner's FRVS rate. If the new owner's principal balance of all current mortgages is equal to or greater than 60 percent of the indexed asset value, then the new owner shall be paid principal and interest on 80 percent of the total asset valuation amortized over 20 years at the interest rate specified in 1.f.(1) above. In addition, the new owner's interest rate shall be used in lieu of the original owner's interest rate in accordance with the limitations described at 1.f.(1). above. Any credits accrued by the previous owner for indexing as described in 1.b. above shall be applied to the new owner.

d. The return on equity or use allowance shall be calculated as per 1.e. above. A per diem shall be calculated for property taxes and insurance, based upon actual historic cost and patient days shown in the latest applicable cost report, as per 1.e. above.

e. The new provider shall be subject to the recapture provisions in Section III.H. of this plan. The new provider's cost basis shall be computed per III.G.3. of this plan.

f. Reimbursement to a new provider for costs of replacement equipment shall be governed by the same provisions affecting the previous provider. The new provider shall enter the phase-in schedule at the point reached by the previous provider at the change of ownership, and shall be reimbursed per 1.j. above for replacement costs.

5. Capital costs which require certificate of need (CON) approval shall be allowed for reimbursement purposes only if the capital expenditure receives approval from the CON office. All cost overruns which require CON approval must also be approved in order to qualify for reimbursement. This section will apply to all providers with Medicaid certification effective on or after July 1, 1991.

	Example 1	**Example 2**
New Facility Cost	$3.0 Million	$4.0 Million
CON Approval	$2.8 Million	$3.0 Million
Medicaid Allowable Cost	$2.5 Million	$3.5 Million
Reimbursable Cost	$2.5 Million	$3.0 Million

Total capital expenditures which are greater than the total amount approved by CON shall not be recognized for reimbursement purposes. In the example above, the reimbursable cost which is considered in rate calculations, is the lower of the new facility cost, CON approval, or the Medicaid allowable cost.

F. Medicaid Adjustment Rate (**MAR**)

For rate periods beginning on and after July 1, 1996, the Medicaid Adjustment Rate shall be calculated as follows:

1. Facilities with 90% or greater Medicaid utilization shall have their MAR equal their WBR as determined in the formula below.
2. Facilities with 50% or less Medicaid utilization shall receive no MAR.
3. Facilities between 50% and 90% Medicaid utilization shall have their MAR as determined by the following formula:

MAR = WBR x MA
WBR = (BR x MAW) X ((Superior + Standard)/All).
MA = ((Medicaid Utilization % - MIN)/(MAX-MIN)) X 100

Definitions:

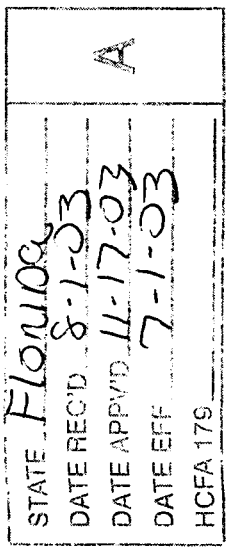
MAR = Medicaid Adjustment Rate
WBR = Weighted Base Rate
MA = Medicaid Adjustment
BR = Base Rate, which is set as the results of step V.B.20e-f
MAW = Medicaid Adjustment Weight, which is set at .045
Superior =Number of Superior Days as described in section V.D.2.(a)
Standard = Number of Standard Days as described in section V.D.2.(a)
All = All superior, standard, and conditional days
MIN = Minimum Medicaid Utilization Amount which is set at 50%
MAX = Maximum Medicaid Utilization Amount which is set at 90%

The result of these calculations will represent the **MAR** to which the provider is entitled. This rate is to be included in the patient care component of the provider's total reimbursement rate.

G. Case-Mix Adjustment

For the rate period beginning on April 1, 1999 through June 30, 1999 and for rate periods beginning on and after July 1, 1999, a case-mix adjustment will be calculated and paid as an add-on to the patient care component of the per diem rate. Effective January 1, 2002, the case-mix adjustment will be eliminated.

1. AHCA will utilize the Minimum Data Set (MDS) Assessments being submitted by nursing facilities to calculate an average case-mix score for each nursing facility participating in the Medicaid program. The average case-mix score will be computed by using the most current version Resource Utilization Grouper (RUGS III), as published by CMS, to classify the MDS assessments into one of thirty-four (34) RUGS III categories. An additional category will be added as a default, which will be assigned the lowest case-mix weight, for those MDS assessments that can not



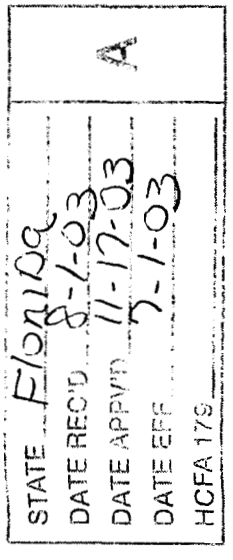
be classified. For purposes of calculating the case-mix score only MDS assessments for Medicaid residents will be utilized to establish the average case-mix score.

a. For the rate period April 1, 1999 through June 30, 1999 the MDS assessments filed for the period October 1, 1998 through February 28,1999 will be used to calculate the average case-mix score. For each July 1 and January 1 rate period subsequent to June 30, 1999 the MDS assessments submitted for the periods October 1 through March 31 and April 1 through September 30, respectivelywill be used in the calculation of the average case-mix score.

b. For the applicable periods as described in Section V.G.1.a. above a case-mix score will be calculated for each MDS assessment submitted for a Medicaid resident. The total case-mix score for each resident will be weighted by the number of days covered by the MDS assessment. Upon computing each individual's weighted case-mix score an average case-mix score will be computed for the facility using all Medicaid residents.

c. An average case-mix score will be calculated for all nursing facilities participating in the Medicaid program as of April 15 and October 15 preceding the July 1 and January 1 rate semesters, respectively. New providers, as defined in V.G.1.d. below, entering the Medicaid program subsequent to the April 15 and October 15 dates will not receive a case-mix adjustment until the following January 1 and July 1 rate semesters, respectively. For the rate period April 1, 1999 through June 30, 1999 only those nursing facilities participating in the Medicaid program as of February 28, 1999 will receive a case-mix adjustment to the patient care component of their total reimbursement rate.

d. For new providers entering the Medicaid program the average case-mix score will be the minimum established under Section V. G. 2.a.below. New providers,



for purposes of calculating the case-mix adjustment, are those in a newly constructed nursing facility or nursing facilities which have not previously participated in the Medicaid program. For existing providers undergoing a change in ownership or operator the MDS assessments submitted for the previous Medicaid provider will be used to establish the average case-mix score for the new provider.

e. No changes or corrections to the case-mix adjustment paid to a nursing facility will be made subsequent to the effective date of the case-mix adjustment.

2. The case-mix adjustment to the patient care component of the total per diem rate will be calculated using the following methodology.

a. Upon calculating the average case-mix score for each nursing facility eligible for the case-mix adjustment, a statewide average case-mix score will be computed. The statewide average case-mix score will be the average case-mix score for all facilities eligible for the case-mix adjustment. The lowest case-mix score will be used as the minimum score for new providers, as described in V.G.1.d. above.

b. An average case-mix rate will be used to calculate each facility's add-on and will be calculated by dividing the available dollars appropriated for the case-mix adjustment by the projected number of Medicaid days in the prospective rate period. For the April 1, 1999 case-mix adjustment the prospective period will be April 1, 1999 through June 30, 1999.

c. The add-on for each individual facility will be computed by multiplying the average case-mix rate determined in Section V.G.2.b. above times each facility's average case-mix score in Section V.G.2.a. above divided by the statewide average case-mix score, calculated in Section V.G.2.a. above.

d. If in total the add-on for each facility times that facility's projected Medicaid days does not equal the total funds appropriated for the case-mix add-on, then each facility's add-on will be proportionately adjusted to ensure that total payments for the case-mix add-on equals the available funds.

H. Direct Care Staff Adjustment (DCSA)

Effective April 1, 2000, a direct care staff adjustment will be calculated and paid as an add-on to the patient care component of the per diem rate. The Agency is to reimburse those nursing facilities who qualify and choose to receive the adjustment for the cost of hiring additional certified nursing assistants and licensed nurses or for the cost of salary or benefit enhancements to retain such staff in these specific classes. The DCSA will be eliminated on January 1, 2002.

1. The qualification criteria used to determine if a provider participates in the distribution of the DCSA includes the following:

   a. The provider must be an active Medicaid provider and submit direct care staffing, patient day and cost data for the base period of January 1, 1999 through June 30, 1999.

   b. The provider must notify the Agency of its intent to participate in the DCSA.

   c. The provider must submit a statement of how it intends to meet legislative intent in spending the DCSA.

   d. The provider must agree to provide follow-up documentation as described in Section 4 below.

2. The direct care staffing ratios shall be calculated and ranked as follows:

   a. From the data received for the period January 1, 1999 through June 30, 1999, the total direct staffing hours per patient day is calculated for CNAs and licensed nurses for each provider.